Base Year. For DMH and DPH hospitals only licensed and/or operated as non-acute hospitals during FY 1993, the base year is the hospital's FY 1993. For hospitals that were not licensed and/or operated as non-acute hospitals during fiscal year 1993, the base year shall be determined pursuant to 114.1 CMR 40.09. For all other hospitals licensed and/or operated as non-acute hospitals during FY 1984, the base year is the hospital's FY 1984, For hospitals that were not licensed and/or operated as non-acute hospitals during fiscal year 1984, the base year shall be determined pursuant to 114.1 CMR 40.09.

CBC. Cost beyond control.

Commission. The Rate Setting Commission was established under M.G.L. c. 6A, s. 32. On July 1, 1996, all functions were transferred to the Division of Health Care Finance and Policy under M.G.L., c. 118G.

Department of Public Health. The Department of Public Health established under M.G.L. c. 17, s. 1.

DHCFP-450. DHCFP-450, Report of Charges and Volume, is a report which documents a hospital's charges and volume, utilized for the purpose of adjusting the cost-to-charge ratio or the payment on account factor should the facility increase their charges beyond the allowable increase specified in 114.1 CMR 40.04(4)(b).

Discontinued Service. A health service, supply or accommodation which conforms in scope to a cost center as defined in Chapter III of the Reporting Manual which:
(a) is included in the adjusted base year cost and which will not be offered during the budget year, or
(b) is being offered and terminated during the budget year.

Direct Cost. The cost of a center as defined by the Reporting Manual after reclassification and recoveries of expense and prior to the allocation of overhead cost to patient care cost centers through the step-down.

Division. The Division of Health Care Finance and Policy, established under M.G.L. c. 118G.

Free Care. The amount, net of free care income or community fund grants, which is charged off by a hospital for hospital care and services, supplies and accommodations provided to indigent persons, pursuant to a plan adopted by the hospital's governing board and filed with the Division. Free care will not include accounting provisions for free care, free care provided to employees or courtesy allowances.

FTEs: Full-time equivalent staff. To compute FTEs, divide the total annual paid hours (including vacation, sick leave, and overtime) for all employees in each cost center by a forty (40) hour standard work week, annualized to a norm of 2080 hours.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, or political subdivision of the Commonwealth.

GPSR. Gross patient service revenue is the total dollar amount of a hospital's charges for services rendered during the reporting period, generally within a fiscal year.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual, promulgated by the Division under 114.1 CMR 4.00.

Intermediate Year. The hospital fiscal year just before the current rate year.

Inpatient Day. HURM standard unit of measure to report care of patients admitted to a hospital including the day of admission, but not the day of discharge. If both admission and discharge occurs on the same day, the day is considered a day of admission and counts as one inpatient day.

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Non-Acute Hospital. A hospital which is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical-surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 19, or any public health care facility.

PAF. Payment on account factor is a percentage applied to charges to calculate a purchaser's discounted reimbursement level.

Public Health Care Facility. A facility operated by the Department of Public Health, the Department of Mental Health, a County of the Commonwealth, or a Soldiers' Home which provides inpatient medical, skilled nursing, or mental retardation care and services and which may provide outpatient medical, mental health, or mental retardation care and services.

Publicly-Aided Individual. A person who receives health care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

Rate Year. For all non-acute hospitals, as defined in 114.1 CMR 40.01, the rate year will be defined as follows:

1. For facilities classified as a "Public Health Care Facility" as defined in 114.1 CMR 40.02, the rate year will be from 7/1 to 6/30.
2. For all other non-acute facilities, the rate year will be 10/1 to 9/30.

Residential Alcoholism Treatment Program. A residential care program for second-time driving while intoxicated offenders approved by the Division of Alcoholism, Massachusetts Department of Public Health pursuant to 105 CMR 166.00.

RFR. Reasonable Financial Requirements.

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities which provide hospital care or services which changes compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

40.03: Reporting Requirements

(1) Reporting Requirements.

(a) Each non-acute hospital shall file with the Division one (1) electronic copy and two (2) paper copies of its Hospital Statement of Costs, Revenues, and Statistics, RSC-403, for each fiscal year within one hundred and twenty days (120) of the close of its fiscal year. Two (2) copies of a hospital's audited financial statements must also be submitted within one hundred and twenty (120) days of the close of its fiscal year. This report is to be completed in accordance with the instructions set forth therein and pursuant to requirements of 114.1 CMR 4.00 and any pertinent administrative bulletins issued by the Division. A copy of the RSC-403 and instructions is incorporated in 114.1 CMR 4.00 and any pertinent administrative bulletins.

(b) Each non-acute hospital shall file with the Division two (2) copies of the DHCFP-450, the Report of Charges and Volume, for the period 7/1/95 through 6/30/96 and the period 7/1/96 through 9/30/96 by January 1, 1997.

(c) Beginning 10/1/96, each non-acute hospital shall file with the Division two (2) copies of the DHCFP-450 within thirty (30) days of the close of the rate year quarter.

(d) Each non-acute hospital shall file with the Division two (2) copies of the hospital's charge book at the beginning of each rate year and at the end of each quarter during which the hospital makes changes.

(e) Each non-acute hospital shall make available all books and records relating to its operation for audit, if requested by the Division.

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(f) All reports, schedules, reporting forms, budget information, books and records which are filed with or made available to the Division shall be certified under pains and penalties of perjury as true, correct and accurate by the chief executive officer or financial officer of the hospital.
(g) The Division may, for cause, extend the filing date for the submission of reports, schedules, reporting forms, budget information, books and records.

(2) Penalties.
(a) All non-acute hospitals are required to submit to the Division documents needed for the calculation of Medicaid rates of payment. These documents include but are not limited to the aforementioned RSC-403 cost reports, the audited financial statements and the DHCFP-450. If the hospital does not submit this complete information in a timely fashion as described above, such hospital may have a reduction applied to their PAF as of the week of Division vote of 5% for every overdue month. Furthermore, this reduction shall continue to accrue in a cumulative manner of 5% for each month of non-compliance. For example, the first adjustment might equal 5%, if requested documentation is not received for an additional month, the adjustment shall equal 10%. The adjustment shall not, in any case, exceed a 50% reduction to the PAF. The PAF will be increased to the hospital's FY 1997 PAF level calculated pursuant to 114.1 CMR 40.04 (4) as of the Division receipt date of hospital compliance.
(b) If a hospital fails to file any data, statistics or other information required under 114.1 CMR 40.03, the Division may request the Attorney General of the Commonwealth to seek additional penalties under M.G,L.118G.

40.04: Rates of Payment for Services Provided to Publicly-Aided Individuals

(1) Applicability. Rates of payment determined under the rules of 114.1 CMR 40.04 shall include:
(a) Payment for all inpatient, outpatient, and well-newborn hospital care and services which are provided by a non-acute hospital to publicly-aided patients.
(b) Payment for administrative days which are provided by a non-acute hospital to publicly aided individuals under Title XIX of the Social Security Act.

(2) General Payment Provisions.
(a) Reimbursement as Full Payment. Each non-acute hospital which provides hospital care and service to publicly-aided individuals shall, as a condition to receipt of payment, accept reimbursement at rates established by the Division, subject to appellate rights set forth in M.G.L. c.118G, as full payment and discharge of all obligations of such individuals. There shall be no supplementation or duplication of payment.
(b) Reimbursement Limitation. Reimbursement determined under 114.1 CMR 40.04 shall not exceed the reimbursement which would result from application of the Principles of Reimbursement of Provider costs established under 42 U.S.C. ss. 1395 et seq., the Medicare Act.
1. For each fiscal year the Division shall calculate the percentage, if any, by which non-acute hospitals' Medicaid payment on account factors (PAFs) must be adjusted in order for the Division of Medical Assistance to comply with the upper limit requirements on Medicaid inpatient and outpatient hospital payments as specified in 42 CFR 447.272 and 42 CFR 447.321. The Division shall calculate the upper limit separately for inpatient services and outpatient services.
2. The Division shall determine whether reimbursement determined under 114.1 CMR 40.00 exceeds the upper limit by comparing the aggregate amount that the Medicare program would pay for Medicaid patients using Medicare principles to the aggregate amount that would be paid using the Medicaid payment on account factors calculated pursuant to 114.1 CMR 40.04 applied to rate year Medicaid charges. If the aggregate payment amount pursuant to 114.1 CMR 40.00 is greater than the aggregate payment amount using Medicare principles, an upper limit adjustment is necessary.
3. If an upper limit adjustment is necessary, the Division shall issue an administrative bulletin setting forth the methodology for calculating such adjustment.

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(3) Rates for Administrative Day Patients. The rate for inpatient services provided to Administrative Day Patients shall be calculated as follows:

(a) For eligible routine services furnished to administrative day patients, the FY 1996 rate of payment will be the lesser of $111 per patient day or the PAF determined pursuant to 114.1 CMR 40.04(4) times the hospital's approved routine charge.

(b) For eligible routine services furnished to administrative day patients, the FY 1997 rate of payment will be the lesser of $113.27 per patient day or the PAF determined pursuant to 114.1 CMR 40.04(4) times the hospital's approved routine charge.

(c) For eligible ancillary services furnished to administrative day patients, the rate of payment shall be equal to the PAF determined pursuant to 114.1 CMR 40.04(4) times the approved charge for the service.

(4) Payment on Account Factor. For all eligible services supplied to publicly assisted patients, other than those cited in 114.1 CMR 40.04(3), the initial rate of payment shall be equal to the product of the PAF and the approved charge for the service.

(a) The FY 1996 PAF shall be computed by dividing the RFR determined pursuant to 114.1 CMR 40.06 by the Approved GPSR for the corresponding rate year, as approved under 114.1 CMR 38.00.

If a hospital's approved GPSR is revised pursuant to 114.1 CMR 38.00, the PAF shall be revised to reflect the new approved GPSR. The PAF shall not be revised to reflect changes in RFR made pursuant to 114.1 CMR 38.00.

In no event shall the PAF exceed 100%.

(b) The FY 1997 PAF shall be computed by dividing the FY 1997 RFR by the FY 1997 GPSR. For hospitals with a rate year beginning 7/1/96, the FY 1997 GPSR shall be the GPSR calculated using the FY 1997 RSC-440 as reviewed and adjusted by the Division. For hospitals with a rate year beginning 10/1/96, the FY 1997 GPSR shall be the FY 1996 GPSR as approved by the Division. This PAF shall remain in effect unless adjusted as described below or until it is superseded by new regulation or a contract with the Division of Medical Assistance.

1. Determination of the Medicaid PAF shall be made in accordance with the information filed on the DHCFP-450 Form.
2. The PAF shall be adjusted downward prospectively, pro-rated for months remaining in the rate year, if the charge per day as reported in the DHCFP-450 Form increases beyond an allowable increase. The allowable increase shall equal the FY 1996 to FY 1997 inflation factor, as calculated pursuant 114.1 CMR 40.08 (2), multiplied by the greater of 1 or the ratio of FY 1997 RFR to FY 1996 RFR.
3. The adjustment factor shall equal the product of a) the inflation factor divided by the sum of one plus the percent increase in charges and b) the greater of one or the ratio of FY 1997 RFR to FY 1996 RFR.
4. The pro-rated adjustment shall be determined as follows:
   a. Step One: i) the adjustment factor multiplied by the total number of months in the year that the increased charges are in effect less ii) the number of months that the increased charges are in effect before the adjusted PAF will take effect.
   b. The pro-rated adjustment shall equal Step One of the adjustment as calculated above divided by the number of months remaining in the year after the adjusted PAF will take effect.
5. The current PAF shall be multiplied by the pro-rated adjustment factor as calculated pursuant to 114.1 CMR 40.04 (4) 4.
6. The Division will determine the lower of the PAF adjusted in 114.1 CMR 40.04 (b) 5. or the PAF currently in effect and will approve a change in the PAF, if applicable, to take effect the first day of the month following the Division's approval.

(c) In addition to the initial rate of payment, a supplementary payment shall be made for all eligible services supplied by non-acute hospitals to publicly-assisted patients who are not given administrative day status. This supplementary payment shall equal the following:

Total Supplementary Payment =

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Total Routine Charges for Administrative Day Patients x PAF
- $113.27 x Number of Administrative Days

(c) The supplementary payment shall be payable by the Division of Medical Assistance to the hospital.

40.05: Residential Alcoholism Treatment Programs

(1) Fee.

(a) The FY 1996 fee for a residential alcoholism treatment program shall be equal to the approved charge times the ratio of RFR determined pursuant to 114.1 CMR 40.06 to the Approved GPSR for the corresponding rate year, as approved under 114.1 CMR 38.00. If a hospital's approved GPSR is revised pursuant to 114.1 CMR 38.00, the ratio shall be revised to reflect the new approved GPSR. The ratio shall not be revised to reflect changes in RFR made pursuant to 114.1 CMR 38.00.

(b) The FY 1997 fee for a residential alcoholism treatment program shall be equal to the charge times the PAF calculated pursuant to 114.1 CMR 40.04(4).

(c)This fee shall be paid in full by the individual served, unless a lesser amount is established by any valid order of a court of competent jurisdiction upon a written finding of indigence or inability to pay pursuant to St. 1982, c. 373. The Commonwealth shall pay to the hospital any difference between the payment made by the individual served and the fee determined under 114.1 CMR 40.05.

(2) Reimbursement as Full Payment. Each non-acute hospital which operates a residential alcoholism treatment program shall, as a condition to receipt of payment, accept reimbursement at rates established by the Division, subject to appellate rights set forth in M.G.L.c. 118G, as full payment and discharges of all obligations of individuals served by such programs. There shall be no duplication or supplementation of payment.

(3) Eligible Providers. Only providers receiving specific permission from the Division of Alcoholism, Massachusetts Department of Public Health may receive reimbursement for residential alcoholism treatment programs under this regulation. Costs associated with residential alcoholism treatment program operating without such permission shall not be included in allowed operating cost.

40.06: Determination of Reasonable Financial Requirements (RFR)

(1) Purpose. The Division shall determine the Reasonable Financial Requirement (RFR) in accordance with CMR 114.1 40.06 for the purposes defined in 114.1 CMR 40.01.

(2) Method of Determination of RFR. The Division will determine the RFR for each non-acute hospital for a rate year by summing [a] the rate year operating requirements, [b] the rate year capital requirement, [c] the rate year working capital requirement, and then subtracting [d] the labor cost recovery pursuant to 40.08(2)(b). The calculation of these elements of RFR is described below.

(a) The rate year operating requirement is the sum of:

1. The base year allowed operating cost under 114.1 CMR 40.07 (2), and
2. The adjusted base year to rate year adjustments calculated pursuant to 114.1 CMR 40.08.

(b) The rate year capital requirement is the sum of:

1. The base year allowed capital cost under 114.1 CMR 40.07 (3), and
2. The adjusted base year to rate year adjustments pursuant to 114.1 CMR 40.08 (6).

(c) The rate year working capital requirement is calculated by multiplying the sum of the rate year operating and capital requirements by 0.0055.

(3) The FY 1997 RFR.

(a) For hospitals with rate years beginning 7/1/96, the FY 1997 RFR is the RFR derived from the FY 1997 RSC-440 as reviewed and adjusted by the Division.

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(b) For hospitals with rate years beginning 10/1/96, the FY 1997 RFR is the FY 1996 RFR approved by the Division. Therefore, the Division will not make adjustments pursuant to 114.1 CMR 40.07 and/or 40.08 for changes affecting costs in FY 1997.

40.07: Determination of Allowed Base Year Cost

(1) Purpose. Except for new non-acute hospitals which have not yet been assigned a base year, the commission will determine Allowed base year Operating Cost for the purpose of establishing a hospital's RFR pursuant to 114.1 CMR 40.07.

(2) Calculation of Allowed Base Year Operating Cost.

(a) For DMH and DPH hospitals only the base year for operating costs shall be FY 1993, and the Division shall utilize the costs reported in audited FY 1993 RSC-403 cost report. For all other hospitals, the base year for operating costs shall be the year recognized by the Division as the base year during FY 1996. For hospitals with a later base year assigned pursuant to 114.1 CMR 40.09, the Division shall utilize the costs reported in the audited RSC-403 cost report for that year.

1. Allowable operating costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual, the HURM Manual and Generally Accepted Accounting Principles.
2. Allowable operating costs do not include costs of personnel or consultants where the primary purpose is, either directly or indirectly, to persuade or seek to persuade hospital employees to support or oppose unionization.

(b) The Division will make a one time adjustment to base year costs to reflect the following:

1. Audit adjustments when the audit is complete.
2. Annualization of partial year costs for which the hospital received adjustments in the RFR approved in the base year.
3. Annualization of partial year reductions in costs as a result of transfers off of costs and discontinued services during the base year.

(3) Calculation of Allowed Base Year Capital Cost. The base year for capital cost is the year recognized as the base year for operating costs. The base year capital cost is calculated by adjusting the hospital's actual base year capital cost for historical depreciation for buildings and fixed equipment, for reasonable interest expense, for amortization and for leases and rentals of facilities. The following limitations apply in the determination of allowable capital costs and, in addition, shall apply to any projected capital acquisitions as set forth in 114.1 CMR 40.08(6).

(a) The Division shall not allow interest expense attributable to balloon payments on financed debt. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments. Requests for interest associated with balloon-type payments must be adjusted to conform to the time period for conventional regular installment loans.

(b) Where there has been a change of ownership after July 18, 1984, the allowable basis of the fixed assets to be used in the determination of the depreciation and interest expense shall be the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The allowed depreciation expense shall be calculated using the full useful lives of the assets.

(c) All costs (including legal fees, accounting, and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984 (by acquisition or merger), for which payment has previously been made by any payer, and which have been included in any portion of the RFR, shall be subtracted from the capital requirement.

40.08 Determination of Base to Rate Year Adjustment of Costs

(1) Purpose. The Division will make a Base to Rate Year Adjustment of Costs in order to determine RFR pursuant to 114.1 CMR 40.06. The Division will make a year to year adjustment to base year costs for additional costs that

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are projected to occur in the rate year due to inflation, changes in volume, costs beyond reasonable control , and new services.

(2) Inflation. The Division shall make an adjustment for inflation prospectively. The Division will adjust allowed operating costs from the base year through the rate year using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category shall be the non-labor portion of the HCFA market basket for non-acute hospitals. There will be no adjustment upward or downward to account for over or under-projection.

(a) The composite inflation index as calculated in accordance with the preceding paragraph will be increased by .02 pursuant to M.G.L. c. 118G.

(b) The Division will recover the additional labor costs for which hospitals were reimbursed according to the provisions of 114.1 CMR 40.07(2)(a), but were not expended on the compensation of technicians, nurses, nursing aides, orderlies and attendants, and occupational, speech, recreational, physical, and respiratory therapists, as required by M.G.L. c.118G. The Division will recover these costs according to the following procedure:

1. Hospitals will report upon the request of the Division, the rate year expenditure of staff positions defined above . Any amount not expended will be excluded from the rate year RFR.
2. The Division may further adjust a hospital's RFR upon audit.

(3) Volume. Allowed base year operating costs shall be further adjusted to reflect reasonable volume increases and decreases as follows:

(a) The Division shall require each hospital to report its costs, revenue, and volume data by HURM designated cost centers. The statistics used for volume adjustment shall be the same as those statistics specified in the HURM Manual. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the base year direct and indirect costs for that cost center divided by base year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost shall be part of the volume used in the computation of the volume allowance. Any allowance due to new service, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

(b) For projected volume increases or decreases from the intermediate year to the budget year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.

(c) For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.

(d) An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the budget year shall be calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the base year to the budget year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

(e) For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease	Allowed Marginal Cost
Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There shall be no downside corridors for volume decreases.

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(f) A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as provided in 114.1 CMR 40.08(3)(e), multiplied by the Allowed Unit Cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

(4) Cost Beyond Hospital Control (CBCs). Allowed base year operating costs shall be further adjusted to reflect costs beyond the reasonable control of the hospital which meet the requirements of 114.1 CMR 40.08(4)(a) and the criteria of 114.1 CMR 40.08(4)(b).

(a) A CBC is an unusual and unforeseen increase in reasonable and allowable costs which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in RFR.

1. A cost shall not be determined to be a CBC if in a prior fiscal year the Division approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.

2. The timing and amount of the increase in costs must be reasonably certain. If the hospital does not begin to expend costs for which it has received a CBC adjustment within six months, the hospital must notify the Division that approved amounts were not expended, and the Division will deduct such costs from RFR.

3. The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the base to rate year inflation and volume allowances.

4. A cost shall be allowed as a CBC only if the amount requested is greater than one tenth 1/10 of 1% of the hospital's total patient care costs.

5. Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in 114.1 CMR 40.08(4)(a)4..

6. Approved costs beyond control shall be only those necessary for the appropriate provision of services. The Division will consider a cost "necessary" only if it can be demonstrated to the satisfaction of the Division that such costs cannot be met through efficient management and economic operation at the existing reimbursable cost level.

(b) The following shall qualify for CBCs provided that the criteria set out in 114.1 CMR 40.08(4)(a) and (b) are met.

1. Costs generated by correcting citations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C. ss. 1395 et seq. and 42 U.S.C. ss. 1396 et seq. An example of this category of CBC is a cost incurred or expected to be incurred within six months of filing to comply with a change in the manual issued after 1984 by the Joint Division on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a cost beyond reasonable hospital control. Hospitals which have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be beyond reasonable hospital control is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable cost beyond control shall not be recognized as additional cost in a hospital's projected reasonable financial requirement. Documentation shall include a copy of the government requirement, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

2. Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a CBC. Documentation shall include a copy of the government requirement, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

3. Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility

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being inadequately insured according to the standards of the hospital industry, or through negligence on part of hospital management, such losses or costs shall not be approved.

4. Allowed operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, ss. 25B - 25G. These costs must be segregated from other allowed operating costs. Any volume allowance due to a DoN shall be netted out if the costs associated with it are submitted as a CBC. The hospital must demonstrate that the increased costs requested are reasonable.

5. Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring CBC and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base for future rate years.

6. Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments. The hospital shall submit documentation of the projected cost savings to be achieved as a result of adjustments to wages and salaries. This adjustment will be considered a non-recurring CBC and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base for future rate years.

7. Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation.

a. Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for wage relief under this exception.

b. The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force.

c. The inflation allowance for direct care staff includes the full amounts granted under 114.1 CMR 40.08(2)(a) and (b).

d. The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum quality of care as determined by the Department of Public Health for current patients. The rate will be determined by the Division with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

(i) Outlier wage rates as defined by the Division shall be excluded from the computation;

(ii) Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region; and

(iii) If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight.

(iv) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application. The determined Medicare Labor Market Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk

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